What works? Coping at work with a common mental health condition

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Presented to the 2016 International Labour Process Conference, Berlin

ABSTRACT

The main goal of the research article is to explore the employment experiences of people who are employed and have a common mental health condition (CMHC), in order to identify the full range of support and disabling processes in such situations. Interviews with people who are employed and have a CMHC were used to achieve the goal. The data was analysed using the social model of disability. The main findings suggest the *what works* process is dependent on a wide-range of varying, multiple and ambiguous organisational and non-organisational variables. The *what works* process is also heavily dependent on a wide-range of informal support behaviour. The study has implications in terms of making a novel contribution to the literature on employment and CMHCs, a contribution to the theories on disability, as well as having practical value for HR professionals.

Sometimes I just get, well I used to get panic attacks just by the mere fact of going to my work and facing people. (Care Assistant).

I don't sleep at night, I spent half the night up awake and then I'm tired for going to work in the morning. (Teaching Assistant).

I was anxious and I was just scared, scared to go back to my work… it was probably silly things… I got to the stage in my work where I was scared to even leave my bag down because I thought… (Civil Servant).

INTRODUCTION

Depression is a common mental health condition (CMHC) causing people to experience depressed mood, loss of interest or pleasure, feelings of guilt or low self-worth, disturbed sleep or appetite, low energy, and poor concentration (Mental Health Foundation, 2015). Anxiety, a similarly CMHC, as well as often co-diagnosed with depression, is said be a lingering apprehension, a chronic sense of worry, tension or dread, the sources of which may be unclear (Swift et al., 2014).

There is said to be no one cause of CMHCs. However, known triggers for CMHCs include, for example, stressful events, illness, personality, family history, giving birth,

loneliness and alcohol and drugs (NHS, 2014). According to the ONS (Beaumont and Lofts, 2013), nearly one in five adults of working age exhibit traits associated with depression or anxiety. Depression and anxiety is more commonly diagnosed in women (21 per cent) than men (16 per cent) and increasingly prevalent in adult working life until reducing from the age of 55, with the 65 to 69 age group the lowest group of working age to display such symptoms (Beaumont and Lofts, 2013). As such, depression and anxiety is likely to affect in the region of 6 million employees out of a total current UK workforce of 31 million (ONS, 2015).

Until relatively recently it was assumed people experiencing CMHCs are unable return to employment or take up paid employment, unless or until they recover (Grove et al., 2005). As such, government initiatives to move people with CMHCs into employment, as well as support those already in employment, have become associated with a whole host of problems, e.g. difficulties competing in competitive labour markets (Boyce et al., 2008), the stigma associated with disclosing a CMHC to an employer and wider colleagues (Brohan et al., 2012), higher than average rates of absenteeism (Brohan et al., 2010), higher than average rates in relation to employee turnover (James et al. 2002), unlawful discrimination (Irvine, 2011) and problematic HR support practices typically mediated through line managers (Sainsbury et al., 2008).

There has been a range of research, however, considering the problems of supporting and providing reasonable adjustments for employees with a CMHC. Such research is noted, for example, for assessing the impact of employment support programmes (Boyce et al., 2008; Lewis et al., 2013), line managers (e.g. Schott, 1999; Holman, 2002; Martin et al., 2015), employee assistance programmes (Bhagat et al., 2007), occupational health (Cox et al., 2004), general practitioners and other mental health professionals (Gray, 2008; Bacon et al., 2010), and human resource/personnel management (Gray, 2008), in supporting people with a CMHC in the work setting. Further research considers how job autonomy (Park and Jang, 2015), organisational discourses on employee well-being (Irvine, 2011), anti-disability practices (Cocker et al., 2014), better management of disclosure (Hielscher and Waghorn, 2015), can help employees with a CMHC cope better at work, as well as preventing work-related CMHCs. Despite such interventions, it is estimated CMHCs account lead to 15 million lost working days per year in the UK (ONS, 2014).

Regardless of an expanding and evolving body of literature on CMHCs and employment, there appears to be a limited range of studies considering a wide range and combination of strategies that can help people with a CMHC remain in employment. Further, there is a scarcity of studies characterised by drawing upon the lived experiences of people who are employed and have a CMHC. It is apparent studies of such kind rarely draw on the social model of disability, an analytical approach allowing an understanding of disabled peoples' experiences (Beckett and Campbell, 2015), as well as creating an opportunity to better theorise the persistence of disabling attitudes in a range of situations (Tregaskis, 2002).

Therefore, the main aim of this article is to explore the realities of employment for employees with a CMHC, with particular attention to *what works* in terms of the range and combination of support such employees receive in order to remain in employment. A further aim is to theorise such experiences and practices in relation to the social model of disability. By taking two such approaches it allows a critique of a range of key sources of support for employees with a CMHC in employment, and as such, highlighting what support is available and where support could be more consistent.

In order to achieve such aims the article is structured as follows. The first main section considers the literature on the main focus of the article - the key issues surrounding support for and barriers to employment for employees with a CMHC, followed by a discussion of the social model of disability. The following section describes and discusses the methodological approach adopted for the current research. In the subsequent section, the findings are presented, analysed and discussed along the lines of themes to emerge from the literature review on CMHC, employment and the social model of disability, as well themes to emerge exclusively from the findings. A final section concludes the wider implications of the findings, with specific attention given to what the findings reveal about where the burden lies and where more could be done in terms of supporting employees with CMHC cope at work.

CMHCS, DISABILITY AND THE WORKPLACE

Overview of CMHCs and employment

It is widely acknowledged employers operating in competitive markets retain a propensity to constrain employee potential for self-realisation (Watson, 2009). As such, disabled employees are likely to be even more constrained in terms of employment-related self-realisation. This view is further confirmed in that UK employers have been found to be resistant to new measures surrounding disability and equality legislation, and where employers do support employees with CMHC it tends to be on an individualised and informal basis (Little et al., 2011). Employer wariness of CMHCs is perhaps explained by further large scale survey research suggesting on the one hand poor employee mental health is connected to high levels of absence, yet on the other hand, does not necessarily impact on levels of employee turnover (Jones et al., Online Early). Further research suggests employers are often ill-equipped to manage employees with a CMHC. Indeed, Caan et al. (2006) report on how there is often inadequate employer support for employees with a CMHC and how many employees with depression feel obliged or pressurised to return to work unwell. What may explain in large part inadequate employee support is how employers tend to view employee absences related to CMHCs. For example, given it is impossible to diagnose a CMHC based on outward appearances alone, managers commonly believe employees with CMHCs are indolent and unreliable

when they are genuinely unwell, with managers often seeing absences related to CMHCs as voluntary (De Lorenzo, 1997).

CMHCs, moreover, are linked in many ways to a range of key organisational issues. For instance, low levels of job satisfaction (Tourigny et al., 2010) and job autonomy (Holman, 2002; Park and Jang, 2015) can lead to increased levels of depression among employees. However, CMHCs appear intertwined with key organisational goals, as CMHCs can often arise or be further exacerbated by key prerogatives of organisations and contemporary employment realities. Indeed, job insecurity is significantly associated with depressive symptoms in employees (Blom et al., Online Early). Further, while organisational change can have a positive impact on employee well-being, concerns remain about the negative impact of organisational change on employee mental health (Loretto et al. 2010). It has been demonstrated that organisations promoting a performance orientated culture may at the same time increase levels of employee depression (Manthorpe et al., 2002).

Sources of support for employees with a CMHC

The literature suggests there are a myriad of ways by which employees with a CMHC can have positive experiences of employment. One such approach is for employees to make use of individual self-coping strategies, or maintaining a positive well-being in the face of organisational and non-organisational stressors. In such situations employees use innate problem-solving skills and rethink difficult situations (Zheng et al., 2016). For Tourigny et al. (2010), employees can consider appraising and re-appraising extrinsic and intrinsic rewards, such as changing job attitudes and behaviours, with such an approach including absence from work at the onset of job burnout and/or depression. A further study highlights the importance to employee well-being of individual coping strategies, including changing the situation, accommodation, symptom reduction, devaluation and avoidance (Cheng et al., 2014). The key issue is self-coping strategies offer employees a particular means to moderate organisational and non-organisational issues that can create or prevent recovery from a CMHC. However, it seems unlikely problems associated with having CHMC will be entirely resolved through individual coping strategies.

The input and expertise of external/third parties represents a further key contributory factor leading to successful employment experiences for employees with a CMHC. How third parties play a supporting role in relation to CMHC and organisations varies somewhat. For instance, Cotti et al.'s (2014) study demonstrates how trade union presence in the workplace can play an important part in the development of flexible working practices, which help mitigate against CMHCs. Employment support programmes, for example, allow employees to overcome a range of barriers to employment, such as providing help in relation to disclosure, explaining a disjointed work history, or navigating the loss of welfare benefits (Boyce et al., 2008). Employment support programmes, moreover, provide a range of services to employees with CMHCs, such as negotiating flexible working patterns and arranging adaptations to the workplace (Lewis et al., 2013). GPs and other mental health practitioners can play a critical part in assisting people achieve their

employment ambitions, as well as maintain better mental health in their working lives (Bacon et al., 2010). GPs and mental health specialists are able to help keep people in employment, for example, by providing return to work advice for patients to share with employers, which could act as a means by which employees and employers can negotiate health and work adjustments. Such mental health experts, moreover, can play a key role by building relationships with providers of employment support programmes (Boyce, 2009).

Perhaps the most significant contributory factor to successful employment for employees with a CMHC involves the direct input of the employer organisation. Indeed, the organisational role in such situations represents a large portion of the literature on employment and CMHCs. In larger organisations, for instance, employers may provide a range of support for employees with a CMHC through employee assistance programmes (EAPs). EAPs in the UK can help individual employees cope with stressful experiences (Bhagat et al. 2007). Cox et al. (2004), moreover, believe occupational health, a function standing at the interface between work and health, can play an increasing role in attempts to reduce or prevent CMHCs in organisations. Occupational health regimes are said to assist in the successful employment of employees with a CMHC in three ways: develop interventions to reduce risk of mental health problems at the organisational level, contribute to work design and management, and play a part in mental health first aid. There is the view the HRM function, particularly in large organisations, can provide a wide-range of pastoral support for employees, although such practices have declined somewhat in recent times due to HRM function moving away from its welfare-orientated past (Gray, 2008).

Linked in with HRM practice are organisation-wide anti-disability practices, some widely applicable and some specific to tackling employee mental well-being. Examples of such practices include stress awareness campaigns or graded absence practices, which allows employees to work-part-time, work full-time hours but perform modified tasks, or perform regular tasks with reduced input, while receiving a combination of sick pay and salary/wage (Cocker et al., 2014). Closely aligned to such practices is the need for effective and appropriate management of disclosure and personal information, or a need to be prepared to revise what information is to be shared in the workplace through the duration of employment (Hielscher and Waghorn, 2015). At a more general level, it has been said employees with a CMHC are more likely to have successful experiences of employment where organisations build strong discourses of mental health well-being (Irvine, 2011), practice transformational leadership (Kensbock and Boehm, Online Early) and incorporate values of more inclusive community-based arts or sports organisations, (Fujimoto et al., 2014). Such practices help employees with CMHCs by, for example, making situations where employees are likely to be better equipped to talk to others when experiencing mental health difficulties, improving employee self-concept, as well as creating common interest activities, and therefore allowing diverse employees to create a greater sense of shared identity.

A further angle on employer input in organisational support for employees with a CMHC involves line management. According to Shift (2009, p. 1):

> The role of line managers in improving access to good work for people with mental health conditions is crucial. A supportive, responsive and inspiring line manager who works to understand the needs of employees can make an enormous difference to the individual whilst helping to break down the stigma and discrimination barrier surrounding mental health issues.

How line managers can be supportive in such situation varies. Generally, line managers play an important supporting role by complimenting formal practices with informal and day-to-day support practices (Roulstone et al., 2003). Line managers, as such, can help train employees with CMHCs to develop coping strategies (Sainsbury et al., 2008), or help create a climate to lift the veil of secrecy and ambivalence, which often surrounds mental health, such as by encouraging open discussions surrounding mental health (Schott, 1999). Line managers can make an important difference by learning to recognise an employee with a CMHC (Johnson and Indvik, 1997) and to encourage employees to seek professional help or advice (Martin et al., 2015). Importantly, line managers can manage emotional responses of colleagues and staff to situations related to employees with a CMHC (Ostell, 1996). In order to avoid an escalation in emotional responses, it has been demonstrated how line managers must put time and effort into building trusting relations with all those potentially affected (Tse, 2004). Further, line managers have the capacity to make important minor adjustments to individual working patterns and allow the employee to have more job control (Holman, 2002).

In sum, it is evident successful support for an employee with a CMHC can vary significantly and likely to involve unique combinations of support practices. However, it is far from clear what combinations of support practices works better than other combinations, especially as what organisations provide will vary even more. Before discussing a research methodology to allow an investigation of support strategies, it is important to discuss an analytical framework to help such an investigation.

The social model of disability

The social model of disability is an analytical framework particularly relevant to investigating workplace inclusion and exclusion. Advocates of the social model of disability do not deny impairment, but instead challenge the conventional view of impairment being the main cause of disabled peoples' economic and social disadvantage (Barnes, 2012). The social model of disability emerged as an alternative conceptualisation of disability because of the limitations associated with medical views of disability. Such a shift came about because an emphasis on individual impairment and difference has historically led to little protection for disabled people (Oliver, 2013). Disability and the social model of disability have been defined as:

> ... the product of specific social and economic structures and aims at addressing issues of oppression and discrimination of disabled people, caused by institutional forms of exclusion and by cultural attitudes embedded in social practices (Terzi, 2004, p. 142).

In this article, disability is not the impairment (i.e. depression and/or anxiety); disability is the social and economic structures of work organisations, such as the attitudes and behaviours of managers and colleagues towards employees with a CMHC, as well as how the economic imperatives of organisations puts absolute limits on reasonable adjustments required to make employment "disability friendly". Disability in this article also relates to the less than helpful behaviour and attitudes of external/third parties to the employment relationship, as well as the individual pursuit of inadequate coping strategies.

While the social model of disability is limited as an analytical framework - it allows a description of the disabling process, rather than explaining it (Beckett and Campbell, 2015); it is not a neat holistic explanation for all aspects of disabled peoples' exclusion (Tregaskis, 2002); and disability is often defined in absolute rather than relative terms (Clarke et al., 2009), the social model of disability is noted by range of relevant and valuable strengths in relation to employment and CMHCs. A key advantage of the social model of disability, as such, is it is an approach allowing a theorisation of the ideological undertones of management attitudes to disability (O'Neill and Urquhart, 2011). The social model of disability privileges work and organisation over and above the individual (Duckett, 2000). The social model is efficient at revealing the most valued disability practices (Lewis et al., 2013), as well as offering an efficient means to tease out differences between exclusionary practices related to different disabilities (Duff and Ferguson, 2011). The approach has already been successfully used to explore the disabling forces faced by employees with a range of hidden disabilities (e.g. see MacDonald, 2009; O'Neill and Urquhart, 2010; Richards and Sang, Online Early).

The principles of the social model of disability can be used in a range of ways so as to explore disabled people's experiences of employment, such as focusing on barriers to employment (Edwards and Boxall, 2010). Such an approach involves principles ideally suited to the current article, including focusing attention on the voices of disabled people (MacDonald, 2009), capturing how people perceive their own disability and how they overcome difficulties encountered (Poria et al., 2011) and getting disabled people to share their experiences regarding attitudinal and social barriers (Naraine and Lindsay, 2011). It is anticipated employment for most people with a CMHC is likely to be far from ideal, with disability/general support practices and barriers to employment co-existing in most instances. The next section considers a methodology to effectively tease out and articulate such realities.

METHODOLOGY

In the line with the prior discussion of the social model of disability, a qualitative approach was adopted as the means to explore support practices and barriers to employment for people with a CMHC. Qualitative methods, moreover, were seen as more ideally suited to the task because they are far more efficient at collecting rich data when compared to quantitative methods (Gilbert et al., 2008). A qualitative approach allows researchers to be flexible and pragmatic, yet at the same time perform a broad and systematic form of research (Davies, 2006).

In order to explore the realities of coping with a CMHC in employment, semi-structured interviews were conducted with 31 people, living and working in the Central Belt of Scotland, with a diagnosis of one or more CMHC (see Table One). Semi-structured interviews were chosen to establish *what works* for, and what barriers are faced by, each individual employee. The participants were made up of nine employees with depression, seven with anxiety and fifteen with a co-diagnosis of depression and anxiety. In more detail, interviews were used to provide insights into the lived experiences of being employed while at the same time as experiencing a CMHC. A professional search organisation was used to recruit from what is essentially a difficult to access research group. A formal diagnosis of a CMHC was not required of prospective participants, although experiences of the diagnosis process and ongoing clinical support was a feature of the interviews.

TABLE ONE GOES HERE

The majority of those interviewed were in their 40s (12) and 50s (10), with an average of age of 45 years (see Table One). The participants were made up of 23 women and 8 men. Occupational details of the participants vary somewhat, from routine front-line work to much more highly skilled work required of, for example, a social worker or manager (see Table One). Interviews were mostly conducted by telephone, with 10 participants agreeing to face-to-face interviews, and took place between autumn 2011 and spring 2012. Interviews ranged from 45 minutes to two hours and averaged approximately 75 minutes in length. All interviews were transcribed verbatim by a professional transcription company, resulting in transcripts with a word count of approximately 255,000 words.

During the interviews participants were asked a range of questions based on the following themes: the nature of the individual's work, stress at work and in domestic situations, workplace and wider support in relation to CMHCs, management of absences related to CMHCs (if applicable) and the impact of CMHCs on workplace relationships. Steps were taken at all stages of the data collection process to protect the interests of the research participants. In order to protect the interests of research participants, information sheets, consent forms and information on specialist support for CMHCs were provided to interviewees.

The interview data were analysed using template analysis (King, 2004). Template analysis was a preferred choice as this approach allows priori codes to be identified

in the literature and for post-hoc codes to be added as data analysis progresses. Template analysis was the approach employed because it is useful in attempts to understand large datasets (Berta et al., 2010). Priori codes identified via an analysis of the literature related to employment and CMHCs, focused very much on, for example, individual coping strategies, including ways by which individual can re-think problems; external/third party support mechanisms, such as GPs and other mental health practitioners; and, organisational support mechanisms, such as occupational health and line managers. Despite consulting a large range of literature related to CMHCs, social model of disability and employment, a range of ad-hoc themes emerged from analysis of the interview data. Ad-hoc codes followed very much in the line with priori codes, but were typically characterised by informal aspects of support practices and barriers to employment. Examples of ad-hoc codes includes, for example, support behaviour provided by colleagues and team members and disabling informal cultures found in employer organisations. In total, 23 priori and ad-hoc codes related to employment support, and 36 priori and ad-hoc codes related to barriers to employment, were eventually used to analyse the dataset.

WHAT WORKS FOR EMPLOYEES WITH A CMHC?

Analysis of the data led to the emergence of a two-fold picture of holding down a job while at the same time as having a CMHC. This analysis revealed a surface account of such situations, principally the sort and amount of support practices, as well as barriers, featured in the experiences of employees with a CMHC (see Table One and as an ongoing reference point for this section of the article). Importantly, analysis of the data provided a much more in-depth understanding of support practices and barriers to employment. In this section of the article, data is presented, analysed and discussed in terms of these two key themes, thus paving the way for a final concluding discussion on the *what works* process.

Supporting employees with a CMHC

As shall be seen later in this sub-section, compared to other forms of support, individual coping strategies did not figure highly in discussions with participants. Indeed, only 10 from 31 participants believed self-coping strategies helped cope with employment. Coping strategies discussed included re-thinking problems (Tourigny et al., 2010; Zheng et al., 2016):

> When I can feel [anxiety] coming on me I just go into my head and say “no, you cannie go down there, you’ve been down that road before” ... I could sit and I could think of everything and I could sit and cry and cry and feel sorry for myself but it wouldn’t do me any good, that’s the way I look at it and I’ve got a lot more positives than I have negatives if you know what I mean and that’s what I keep thinking on to get me by. (Interview 30, Georgina, General Retail Assistant).

Coping strategies discussed included reference to physically changing the situation that is a key cause of the CMHC (Cheng et al., 2014):

> [Workload] does affect your home life as well but I try and not let it. I'm very much now, I go in and do my hours and I'm home. Whereas before I would have stayed on another hour or two hours but no, not anymore. (Interview 28, Brodie, Police Officer).

Despite being the least likely form of support discussed by participants, it is evident where such strategies are used they have the potential to make an important difference for the individual concerned.

External or third party organisations provided marginally the most common and consistent forms of support for employees with a CMHC. Given all participants were in employment and holding down a job, it was unsurprising to hear no discussions of employment support programmes (Boyce et al., 2008) in interviews. Instead, four forms of support provided by external/third party organisations dominated discussions with participants. The support of a GP, for example, figured positively in the support process for all but two of the participants (Bacon et al., 2010):

> Well what [the GP has] done is he's said to me "any time if you feel things are getting too bad come and tell us", I mean sometimes me and him would sit and blether until probably everybody's appointments were late, do you know what I mean? (Interview 1, Isla, Head Controller).

Just over half of the participants spoke highly of the support provided by a mental health practitioner, such as professional counsellor, when seeking help to cope with a CMHC (Boyce, 2009):

> ... I went to the counselling and I felt that helped a lot more, you know, I felt that was better for me, you know I was able to kind of speak and just basically give my worries if you know what I mean... (Interview 18, Rory, Sales Assistant).

A slightly lower figure reported working in an organisation where trade unions were recognised. Several of such individuals believed trade union representation (Cotti et al., 2014) specifically played an important part in the support process:

> ...the union person was constantly in touch with me and he was trying to say "look you've not done anything wrong" he was really supportive, he was supportive of me and we went to different meetings... (Interview 27, Emily, Civil Servant).

A handful participants, moreover, discussed how close dealings and interactions with customers of the organisation provided an important distraction from anxiety ridden thoughts:

> ...just say, for instance, I was working on my own, just say it was a library or something like that, or just say I was in Asda and packing shelves, I dinnae think I

> could cope... in hairdressing, it's the client you're dealing with and they've all got a different story to tell you. (Interview 17, Alice, Hairdresser).

However, it was close family and friends that came closest in terms in numerical terms to matching the support provided by GPs. Such support appeared important in terms of having understanding and trusting people around at critical times:

> ... [my partner] is quite good [when I'm having a bad time]; he'll just go away and leave me, he's quite laid back, he doesn't really argue back, he's probably really good for me than other relationships I've been in... (Interview 7, Isabella, Hairdresser and Care Assistant).

> Also I've got a lot of support in the sense that I've got a good family and good friends and a good partner, so I think that sort of helps me break out of it once in a while... (Interview 23, Julia, Call Centre Operator).

In terms of support provided entirely and exclusively by organisations, discussions with participants suggested such forms of support are marginally less common than support provided by external/third parties. The spread of access to organisational support was more irregular than in the case of external/third party support. Indeed, discussion of organisational support varied from not being available or taken up by three participants (interviewees 4, 23 and 24) to as many as six forms of organisational support discussed by one interviewee (interviewee 29).

In terms of the specifics of support provided by organisations, the majority of participants discussed drawing on support from line managers. Line management support varied across discussions with participants, yet typically took the form of, for example, informal day-to-day minor adjustments to the daily routine (Roulstone et al., 2003):

> [My line manager is] really understanding and I can say to her this is happening and she'll say: "I'll get somebody else to do that job". (Interview 2, James, Limousine Driver).

Line managers making minor adjustments to working patterns (Holman, 2002) were a further common feature of the interviews:

> ... [my manager] could understand, and like a lot of maybe my tasks that I had if I didn't feel like being out on the shop floor, or whatever, he would [say:] "just do whatever in the back shop away from people". (Interviewee 21, Sarah, Care Assistant).

Interviews revealed details of how line managers could encourage employees to seek professional help related to an apparent change in mental well-being (Martin et al., 2015):

> … [my line manager] was egging me to go to the doctor and she knew that there wasn't something quite right when I went back to work as well, that I was feeling down and whatever. (Interviewee 8, Niamh, Domestic Assistant).

However, little evidence emerged from interviews concerning line managers taking a wider or strategic stance in relation to CMHCs, such as, training employees to cope better (Sainsbury et al., 2008) and encouraging open discussion about mental well-being (Schott, 1999). Further, despite difficulties discussed concerning the attitudes and behaviour of colleagues, little evidence emerged from interviews concerning line managers managing emotional responses of colleagues towards employees with a CMHC (Ostell, 1996).

Approximately one-third of the participants, moreover, typically employed by large public and private organisations, discussed receiving support from an EAP (Bhagat et al., 2007):

> [I can access an EAP] through a company called [WXYZ] and I've used them myself, they're very good. (Interviewee 14, Lucy, Telephone Advisor).

Provisions by occupational health (Cox et al., 2004) were common features of interviews with employees of large, often public sector organisations:

> And [occupational health] do an assessment on you and they send the report back to the work. Well, they done that for me and the work agreed that I would need to… I've not had any problems since. (Interviewee 16, Katie, Civil Servant).

HR practice cropped up in similar scenarios and evidence of a pastoral role for HR in relation to CMHCs emerged from the findings (Gray, 2008):

> No, it would have got to that stage [discipline], but it was Human Resources that were involved, they were quite good, well you sort of phone them up... (Interviewee 29, Jessica, Sales Support Manager).

However, anti-disability practices (Cocker et al., 2014) appeared a minor of feature of the findings, except in the case of some larger organisations:

> I work for a big organisation, so yeah, they do and we have like health checks and all that, if you want to go along to them, we have opportunities to go to that, we've opportunities to go to like alternative therapies for stress... (Interviewee 25, Maria, Venue Supervisor).

Finally, but far from least, the role of trusted individual colleagues and in some case the wider team, was a common feature of interview discussions. Indeed, more than half of participants discussed such support and the importance of having understanding colleagues in close vicinity:

> Yes, there was one colleague that did just that, you know, generally: how are you doing? And again, some days you would be doing really well and you'd say yeah, I'm fine actually... (Interviewee 6, Erin, Civil Servant).

> Well, the teachers I was working with at the time, yeah, were very supportive and my other teaching assistants, yeah they were too. (Interviewee 11, Iona, Teaching Assistant).

The picture surrounding coping at work with a CMHC, however, would be far from complete without a consideration of the range of barriers widely discussed in the interviews.

Barriers to employment for employees with a CMHC

Analysis of the interview data in relation to employment barriers revealed a range of general noteworthy observations. Firstly, there was an evident variation in the number of barriers to employment employees discussed by participants, from zero (interviewee 9) to fourteen (interviewee 1). Secondly, many of the support practices discussed in the previous section, either individual, external/third party or organisational, had the potential to be interpreted or experienced as barriers to employment. Interestingly, barriers related to employer organisations outweighed barriers related to individual coping strategies and external/third party organisations. Finally, no one barrier dominated discussions with interviewees, therefore suggesting problems with employment and CMHCs are based on a wide-range of combinations of barriers to employment.

In terms of specific barriers to employment, discussions with participants revealed two key barriers to employment related to individual attempts to cope at work with a CMHC. Indeed, the stigma of having a CMHC (Brohan, et al. 2012) affected the employment experience of nearly 60 per cent of the interviewees:

> No, I've never even gave [counselling] a thought to be honest. I mean I know there's probably groups out there you know that could help me – it's just a thing I've never even thought about, because sometimes I'm a bit embarrassed with it. (Interviewee 10, Rose, Caretaker Cleaner).

Linked to stigma, a further key barrier related to limited or problematic individual coping strategies. If anything, such instances of coping strategies made the employment situation worse:

> I should have went to the Doctor at the beginning. As I say, being a proud man it was a case of, "no I'll work through it, I'll live through it", and stuff like that you know, which was silly. (Interview 18, Rory, Sales Assistant).

External/third parties were linked to barriers to employment. For instances, in approximately 30 per cent of participants discussed difficulties related to interactions with GPs and mental health specialists:

> The doctor gave me the usual tablets and stuff to try and get some sleep, but I realised early that that wasn't the route I wanted to go down, so I stayed off of them... I would always feel that I'm just a number with them, you know, I'm just another face that walks in, tells them their problems, and the guy says well, you'll get over it, take your tablets, you know (Interviewee, Harris, Joiner).

Trade unions proved to be problematic in about 25 per cent of cases, with a lack of presence a key issue:

> On the nightshift we never really got to see a union representative or anything, we used to like when I'd done day shift and back shift before we used to get to meet her at least every month and filled you in with what's going on... (Interviewee, Niamh, Domestic Assistant).

Organisational factors, however, proved to be the most significant aspect of employment barriers discussed in the interviews. By far the biggest problem involved line manager behaviour and attitudes (Sainsbury et al., 2008), as discussed by approximately 50 per cent of all participants:

> Well I had one experience with [my line manager], he more or less says: "look you'll just need to get on with it," ken what I mean, and more or less "give yourself a shake" ... [he doesn't] really understand what you're going through. (Interviewee 5, Elidh, Care Assistant).

The same could be said for colleagues and team members who were also widely discussed in terms of being barriers to employment:

> No I never really needed to tell them I just… the younger ones didn't even ask, they weren't interested and one older one didn't really ask either, so no, nobody asked so I didn't say. (Interviewee 20, Imogen, Bar Person).

In quite a different vein, approximately one-third of participants discussed how the pressures/intensity of a performance orientated culture (Manthorpe et al., 2002) got in the way of a pre-existing CMHC or went on to play a part in generating a CMHC:

> So it does get a bit stressful sometimes, a lot of work... it's like corporate culture gone wild, do you know what I mean, everything's like forced down your throat about how you have to support your managers, you have to do this, this, this... (Interviewee 13, Caitlin, Bank Associate).

HR practice (Sainsbury et al., 2008), particularly in terms of a pastoral role, was discussed during interviews as a key barrier to employment. HR practices in such situations came across as a distant and detached management function:

> [I haven't managed to speak to HR] because the office is in Birmingham. I never had nothing, the only contact details I had was Payroll department, uniform department and my supervisor. (Interviewee 15, Callum, Security Guard).

Further HR-related practices, such as managing absenteeism (Coker et al., 2014), were seen as problematic in relation to a CMHC:

> I believe in absence management and I think it should be used for people who take every Monday off because they're on the piss all weekend but when it comes to people who are obviously having serious difficulties then it's really quite punitive. (Interviewee 19, Thea, Social Worker).

Approximately a quarter of the participants discussed a range of other organisational factors mitigating against otherwise positive experiences of employment. These included difficulties arising from the personal impact of organisational change (Loretto et al., 2010):

> It's not even subtle changes it's been wholesale changes... Well the stress for me was when I came into this position I had a massive clear up job on because there was just total miss-management prior to when I took over with regards to… (Interviewee 24, Cameron, Team Manager).

Finally, informal cultures, such as sexual discrimination and/or bullying behaviour, represented a further unwanted range of barriers to coping at work with a CMHC:

> I've always worked in basically a male environment which didn't really bother me, do you know what I mean, I could work fine with them, but when you were getting undermined I think… it was a transport company I worked for and a lot of them, a lot of the people that came from the other place obviously that were the bosses and things like that found it very hard that a female was in charge. (Interviewee 1, Isla, Head Controller).

Despite earlier reporting a wide range of support available to employees with a CMHC, the interviews made it quite apparent how good parts of such support were often weakened and undermined by a similarly wide-range of practices-come-barriers.

DISCUSSIONS AND CONCLUSIONS

The vast majority of literature regarding CMHCs and employment is characterised by a focus on particular types of support and disabling processes. The aim of this research article, however, was to explore the experiences of employees with a CMHC in relation to the full range of available support practices and employment barriers. This aim was to be achieved by drawing on a methodology based on lived experience interviews and a theoretical framework informed by the social model of disability. By adopting a novel approach to exploring employment and CMHCs, the study threw up a wide-range of key and important findings. These findings are summarised as follows.

The first key finding was the support needed by employees with a CMHC and the barriers faced by people in employment with a CMHC are both interlinked three-way processes, and reliant upon a combination of factors related to the individual, external/third party organisations and employer organisations. In other words, in one sense, the *what works* process is dependent on the commitment and effort from a range of loosely connected stakeholders. Such parties, moreover, operate in different and separate ways to each other. Similarly, the disabling process is dependent upon broadly the same factors and processes. Further, the three-way process is not even, nor is it consistent. At the least, the evidence suggests both employees and employers could be more consistent in terms of making the *what works* process work.

The criticality of a cross the board personal support behaviour in the *what works* process represents the second key finding. While it would be unreasonable to suggest support behaviour compares with the input to the process by GPs and mental health specialists, participants consistently discussed how support behaviour made an important difference to their day-to-day lives. Indeed, the findings suggested support behaviour should come from the full range of stakeholders to the support process, including GPs, partners, family members, close friends, line managers, HR practitioners, trade union representatives, colleagues, wider team members and even customers.

The third key finding is the *what works* process appears to be a largely rudderless process, with one stakeholder rarely taking full ownership of the problem. Further, support, and ultimately barriers to employment, appeared to be determined almost on a random basis. However, while it was evident some employer organisations went to considerable lengths to support employees with a CMHC, much of the good work was often undone by a range of practices attributed to the employer organisation.

A fourth and final key finding is the vast majority of employees with a CMHC were far from thriving in their employment. The findings were more indicative of employees variously getting by, rather than thriving at work, with no guarantees the *what works* process would continue to lean towards a positive outcome. A good analogy for the *what works* process would be of a double-edged sword - a precarious situation, with the potential to provide both favourable and unfavourable outcomes. For instance, the *what works* process is likely to stop functioning should an employee be expected to rely on a less than supportive line manager or GP.

Collectively, the findings have wider implications. Firstly, the study makes for a unique and novel contribution to the literature on employment and CMHCs. This has been achieved by harnessing the voices of employees with a CMHC, but more importantly, allowing employees to say *what works* for them. A second wider implication is the study has further strengthened the role and value of using the social model of disability as a means to theorise disabled employees' experiences of employment. By taking this approach, the study extends the social model of disability by identifying the importance of considering multiple and mutual facets to

both the disabling and enabling process. The study has wider implications in terms of practical value, particularly in terms of informing HR practice. The study, for example, stresses to HR practitioners both the wider and finer aspects of supporting an employee with a CMHC, especially in terms of highlighting the many informal, subtle and inter-linked and inter-dependent aspects of the *what works* process.

The study in question, however, is limited in a range of ways, with such limitations representing an important part of making recommendations for further research in this area of employment and disability studies. For instance, further research on employment and CHMCs, considering the full range of facets to the *what works* process, is likely to benefit from quantitative methods and much larger samples of employees. Quantitative methods would allow for the consideration of the full-range of variables related to the *what works* process, as well as variables given limited coverage in this article, such as age, gender, job and cause of CMHC. The current study is limited in terms of being a snapshot approach to exploring employment and CMHCs. Further research would almost certainly benefit from quantitative or qualitative longitudinal methods, which would allow for patterns to be explored as the *what works* process evolves and no doubt changes over time.

Acknowledgements

This research article was funded by the Scottish Association of Mental health.

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	PSEUDONYM	MENTAL HEALTH CONDITION	GENDER	AGE RANGE	JOB	COPING PRACTICES	EXTERNAL/THIRD PARTY SUPPORT	ORGANISATIONAL SUPPORT PRACTICES	BARRIERS TO EMPLOYMENT
1.	Isla	Anxiety	Female	40s	Head Controller	1	3	1	14
2.	James	Depression	Male	40s	Limousine Driver	0	3	2	1
3.	Alexander	Depression and anxiety	Male	50s	Lorry Driver	0	2	2	3
4.	Harris	Depression and anxiety	Male	40s	Joiner	0	2	0	2
5.	Eilidh	Depression and anxiety	Female	50s	Care Assistant	0	3	2	7
6.	Erin	Depression and anxiety	Female	40s	Civil Servant	0	3	2	8
7.	Isabella	Depression and anxiety	Female	20s	Hairdresser and Care Assistant	0	3	1	1
8.	Niamh	Depression and anxiety	Female	20s	Domestic Assistant	0	2	2	7
9.	Esme	Depression	Female	40s	Bank Associate	2	4	5	0
10.	Rose	Depression	Female	50s	Caretaker Cleaner	1	3	1	9
11.	Iona	Depression	Female	40s	Teaching Assistant	0	5	3	4
12.	Lauren	Depression and anxiety	Female	50s	Front House Manager	0	4	3	3
13.	Caitlin	Depression	Female	30s	Bank Associate	0	2	4	10
14.	Lucy	Depression and anxiety	Female	50s	Telephone Advisor	0	3	4	6
15.	Callum	Depression	Male	20s	Security Guard	0	3	2	3
16.	Katie	Depression and Anxiety	Female	40s	Civil Servant	2	3	4	7
17.	Alice	Anxiety	Female	40s	Hairdresser	0	3	2	3
18.	Rory	Depression	Male	50s	Sales Assistant	0	3	3	5
19.	Thea	Anxiety	Female	50s	Social Worker	0	3	4	3
20.	Imogen	Depression	Female	20s	Bar Person	0	3	2	4
21.	Sarah	Depression and anxiety	Female	40s	Care Assistant	0	3	4	4
22.	Rachel	Depression and anxiety	Female	60s	Special Needs Assistant	0	3	3	1
23.	Julia	Depression and anxiety	Female	30s	Call Centre Operator	0	2	0	8
24.	Cameron	Depression	Male	30s	Team Manager	1	2	0	8
25.	Maria	Depression and	Female	30s	Venue Supervisor	0	4	4	4

		anxiety							
26.	Beth	Anxiety	Female	50s	Social Worker	0	3	5	3
27.	Emily	Anxiety	Female	50s	Civil Servant	1	3	4	3
28.	Brodie	Depression	Male	40s	Police Officer	1	3	4	10
29.	Jessica	Anxiety	Female	50s	Sales Support Manager	1	3	6	4
30.	Georgia	Depression and anxiety	Female	40s	General Retail Assistant	1	3	2	10
31.	Andrew	Depression and anxiety	Male	50s	Painter and Decorator	2	2	1	4
					Average	0.4	3.0	2.6	5.1

Table One: Details of research participants, by CMHC, gender, age range, job/occupation, and discussed support practices and barriers to employment